COMMITTEE ON HEALTH

SENATE AMENDMENTS TO H.B. 2462

(Reference to House engrossed bill)

Strike everything after the enacting clause and insert:

"Section 1. Section 36-2912, Arizona Revised Statutes, is amended to read:

36-2912. Healthcare group coverage; program requirements for small businesses and public employers; related requirements; definitions

A. The administration shall administer a healthcare group program to allow willing contractors to deliver health care services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). In ~~the absence of a willing contractor~~ COUNTIES WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS, the administration may contract directly with any health care provider or entity. The administration may enter into a contract with another entity to provide administrative functions for the healthcare group program.

B. Employers with ~~one~~ TWO eligible ~~employee~~ EMPLOYEES or up to an average of fifty eligible employees under section 36-2901, paragraph 6, subdivision (d):

1. May contract with the administration to be the exclusive health benefit plan if the employer has five or fewer eligible employees and enrolls one hundred per cent of these employees into the health benefit plan.

2. May contract with the administration for coverage available pursuant to this section if the employer has six or more eligible employees and enrolls eighty per cent of these employees into the healthcare group program.

3. Shall have a minimum of ~~one~~ TWO and a maximum of fifty eligible employees at the effective date of their first contract with the administration.

~~C. The administration shall not enroll an employer group in healthcare group sooner than one hundred eighty days after the date that the employer's~~

~~health insurance coverage under an accountable health plan is discontinued. Enrollment in healthcare group is effective on the first day of the month after the one hundred eighty day period. This subsection does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.~~

~~D.~~ C. Employees with proof of other existing health care coverage who elect not to participate in the healthcare group program shall not be considered when determining the percentage of enrollment requirements under subsection B of this section if either:

1. Group health coverage is provided through a spouse, parent or legal guardian, or insured through individual insurance or another employer.

2. Medical assistance is provided by a government subsidized health care program.

3. Medical assistance is provided pursuant to section 36-2982, subsection I.

~~E.~~ D. An employer shall not offer coverage made available pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally designated plan.

~~F.~~ E. An employee or dependent defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in healthcare group on a voluntary basis only.

~~G.~~ F. Notwithstanding subsection B, paragraph 2 of this section, the administration shall adopt rules to allow a business that offers healthcare group coverage pursuant to this section to continue coverage if it expands its employment to include more than fifty employees.

~~H.~~ G. The administration shall provide eligible employees with disclosure information about the health benefit plan.

~~I.~~ H. The director shall:

1. Require that any contractor that provides covered services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) provide separate audited reports on the assets, liabilities

and financial status of any corporate activity involving providing coverage pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

2. PROHIBIT THE ADMINISTRATION FROM REIMBURSING A NONCONTRACTING HOSPITAL FOR SERVICES PROVIDED TO AN ELIGIBLE EMPLOYEE AT A NONCONTRACTING HOSPITAL EXCEPT FOR EMERGENCY MEDICAL SERVICES AND POST-STABILIZATION SERVICES, AS PRESCRIBED BY THE ADMINISTRATION BY RULE.

~~2.~~ 3. Beginning on July 1, 2005, require that a contractor, the administration or an accountable health plan negotiate reimbursement rates ~~and not use the administration's reimbursement rates established pursuant to section 36-2903.01, subsection H, as a default reimbursement rate if a contract does not exist between a contractor and a provider.~~ , EXCEPT THAT THE REIMBURSEMENT RATE FOR A NONCONTRACTING HOSPITAL SHALL BE ONE HUNDRED FOURTEEN PER CENT OF THE REIMBURSEMENT RATES ESTABLISHED PURSUANT TO SECTION 36-2903.01, SUBSECTION H FOR EMERGENCY MEDICAL SERVICES AND POST-STABILIZATION SERVICES.

~~3.~~ 4. Use monies from the healthcare group fund established by section 36-2912.01 for the administration's costs of operating the healthcare group program.

~~4.~~ 5. Ensure that the contractors are required to meet contract terms as are necessary in the judgment of the director to ensure adequate performance by the contractor. Contract provisions shall include, at a minimum, the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required for the healthcare group program, with the administration or the department of insurance for the performance of health service contracts if funds would be available to the administration from the other security on the contractor's default. In waiving, or approving waivers of, any requirements established pursuant to this section, the director shall ensure that the administration has taken into account all the obligations to which a contractor's security is associated. The director

may also adopt rules that provide for the withholding or forfeiture of payments to be made to a contractor for the failure of the contractor to comply with provisions of its contract or with provisions of adopted rules.

~~5.~~ 6. Adopt rules.

~~6.~~ 7. Provide reinsurance to the contractors for clean claims based on thresholds established by the administration. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

~~J.~~ I. With respect to services provided by contractors to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), a contractor is the payor of last resort and has the same lien or subrogation rights as those held by health care services organizations licensed pursuant to title 20, chapter 4, article 9.

~~K.~~ J. The administration shall offer a health benefit plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. ~~The administration shall provide a health benefit plan to each small employer without regard to health status-related factors if the small employer agrees to make the premium payments and to satisfy any other reasonable provisions of the plan and contract.~~ The administration shall offer to all small employers the available health benefit plan and shall accept any small employer that applies and meets the eligibility requirements. In addition to the requirements prescribed in this section, for any offering of any health benefit plan to a small employer, as part of the administration's solicitation and sales materials, the administration shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The administration shall provide information concerning the following:

1. Provisions of coverage relating to the following, if applicable:

(a) The administration's right to establish premiums and to change premium rates and the factors that may affect changes in premium rates.

(b) Renewability of coverage.

(c) Any preexisting condition exclusion.

(d) The geographic areas served by the contractor.

2. The benefits and premiums available under all health benefit plans for which the employer is qualified.

~~L.~~ K. The administration shall describe the information required by subsection ~~K~~ J of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefit plan. This requirement is satisfied if the administration provides the following information:

1. An outline of coverage that describes the benefits in summary form.

2. The rate or rating schedule that applies to the product, preexisting condition exclusion or affiliation period.

3. The minimum employer contribution and group participation rules that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

~~M.~~ L. A contractor is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

~~N.~~ M. At least sixty days before the date of expiration of a health benefit plan, the administration shall provide a written notice to the employer of the terms for renewal of the plan.

~~O.~~ N. The administration may increase or decrease premiums based on actuarial reviews of the projected and actual costs of providing health care benefits to eligible members. Before changing premiums, the administration must give sixty days' written notice to the employer. The administration may cap the amount of the change. FOR EACH CONTRACT PERIOD THE ADMINISTRATION SHALL SET PREMIUMS THAT IN THE AGGREGATE COVER PROJECTED MEDICAL AND ADMINISTRATIVE COSTS FOR THAT CONTRACT PERIOD. THE ADMINISTRATION SHALL BASE THIS PROJECTION ON AN ANALYSIS THAT IS DETERMINED AND CERTIFIED BY AN INDEPENDENT ACTUARY.

~~P.~~ O. The administration may consider age, sex, income, HEALTH STATUS-RELATED FACTORS and community rating when it establishes premiums for the healthcare group program. IF HEALTH STATUS-RELATED FACTORS ARE CONSIDERED, THE PREMIUM RATE MAY NOT VARY BY MORE THAN SIXTY PER CENT ABOVE THE BASE COMMUNITY RATE THAT AN INDIVIDUAL OF SIMILAR PLAN SELECTION, AGE, SEX, INCOME, FAMILY SIZE, FAMILY COMPOSITION AND GEOGRAPHIC AREA WOULD PAY, AND THE PREMIUM RATE SHALL NOT BE LESS THAN THE BASE COMMUNITY RATE.

~~Q.~~ P. Except as provided in subsection ~~R~~ Q of this section, a health benefit plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability.

~~R.~~ Q. A health benefit plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefit plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under this section.

2. The contractor shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

~~S.~~ R. The contractor shall calculate creditable coverage according to the following:

1. The contractor shall give an individual credit for each portion of each month the individual was covered by creditable coverage.

2. The contractor shall not count a period of creditable coverage for an individual enrolled in a health benefit plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The contractor shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period for any health coverage.

~~T.~~ S. The contractor shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The contractor shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer or is in a waiting period for benefits under a health benefit plan offered by a contractor. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period, the contractor shall count a period of creditable coverage without regard to the specific benefits covered during that period. A contractor shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth. A contractor shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

~~U.~~ T. The written certification provided by the administration must include:

1. The period of creditable coverage of the individual under the contractor and any applicable coverage under a COBRA continuation provision.

2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the health plan.

~~V.~~ U. The administration shall issue and accept a written certification of the period of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

3. The name, address and telephone number of the issuer providing the certificate.

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For THE purposes of this subdivision, eighteen months means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

~~W.~~ V. The administration shall provide any certification pursuant to this section within thirty days after the event that triggered the issuance of the certification. Periods of creditable coverage for an individual are established by presentation of the certifications in this section.

~~X.~~ W. The healthcare group program shall comply with all applicable federal requirements.

~~Y.~~ X. Healthcare group may pay a commission to an insurance producer. ~~To receive a commission, the producer must certify that to the best of the producer's knowledge the employer group has not had insurance in the one hundred eighty days before applying to healthcare group.~~ For the purposes of this subsection, "commission" means a one time payment on the initial enrollment of an employer.

~~Z.~~ Y. On or before June 15 and November 15 of each year, the director shall submit a report to the joint legislative budget committee regarding the number and type of businesses participating in healthcare group and that includes updated information on healthcare group marketing activities. The director, within thirty days of implementation, shall notify the joint legislative budget committee of any changes in healthcare group benefits or cost sharing arrangements.

Z. THE ADMINISTRATION SHALL SUBMIT THE FOLLOWING TO THE JOINT LEGISLATIVE BUDGET COMMITTEE:

1. QUARTERLY REPORTS REGARDING THE FINANCIAL CONDITION OF THE HEALTHCARE GROUP PROGRAM. THE REPORTS SHALL INCLUDE THE NUMBER OF PERSONS AND EMPLOYER GROUPS ENROLLED IN THE PROGRAM AND MEDICAL LOSS INFORMATION AND PROJECTIONS.

2. AN ANNUAL FISCAL AUDIT.

3. THE ANALYSIS THAT IS USED TO DETERMINE PREMIUMS PURSUANT TO SUBSECTION N OF THIS SECTION.

AA. BEGINNING ON JULY 1, 2009, AND EACH FISCAL YEAR THEREAFTER, HEALTHCARE GROUP SHALL LIMIT EMPLOYER GROUP ENROLLMENT TO NOT MORE THAN TEN PER CENT MORE THAN THE NUMBER OF EMPLOYER GROUPS ENROLLED IN THE PROGRAM AT THE END OF THE PRECEDING FISCAL YEAR. ENROLLMENT PRIORITY SHALL BE GIVEN TO UNINSURED GROUPS.

~~AA.~~ BB. For the purposes of this section:

1. "Accountable health plan" has the same meaning prescribed in section 20-2301.

2. "COBRA continuation provision" means:

(a) Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.

(b) Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974.

(c) Title XXII of the public health service act.

(d) Any similar provision of the law of this state or any other state.

3. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan, as defined in section 20-2301, issued by a health plan.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

(h) A health benefits risk pool operated by any state of the United States.

(i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.

(j) A public health plan as defined by federal law.

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (22 United States Code section 2504(e)).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(m) A policy or contract issued by a health care insurer or the administration to a member of a bona fide association.

4. "Eligible employee" means a person who is one of the following:

(a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(b) A person who works for an employer for a minimum of twenty hours per week or who is self-employed for at least twenty hours per week.

(c) An employee who elects coverage pursuant to section 36-2982, subsection I. The restriction prohibiting employees employed by public agencies prescribed in section 36-2982, subsection I does not apply to this subdivision.

(d) A person who meets all of the eligibility requirements, who is eligible for a federal health coverage tax credit pursuant to section 35 of the internal revenue code of 1986 and who applies for health care coverage through the healthcare group program. The requirement that a person be employed with a small business that elects healthcare group coverage does not apply to this eligibility group.

5. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct ~~analysis~~ ANALYSES of genes or chromosomes.

6. "Health benefit plan" means coverage offered by the administration for the healthcare group program pursuant to this section.

7. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health plan including:

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

8. "Hospital" means a health care institution licensed as a hospital pursuant to chapter 4, article 2 of this title.

9. "Late enrollee" means an employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period that is provided under the terms of the health benefit plan if the initial enrollment period is at least thirty-one days. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment is received within thirty-one days after the person becomes a dependent. An employee or dependent shall not be considered a late enrollee if:

(a) The person:

(i) At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefit plan.

(ii) Lost coverage under a public or private health insurance policy or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.

(iii) Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a COBRA continuation provision.

(iv) Requests enrollment within thirty-one days after the date of marriage.

(b) The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment period.

(c) The person becomes a dependent of an eligible person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.

10. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefit plan issued by a contractor. Preexisting condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information.

11. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefit plan offered by a contractor.

12. "Small employer" means an employer who employs at least ~~one~~ TWO but not more than fifty eligible employees on a typical business day during any one calendar year.

13. "Waiting period" means the period that must pass before a potential participant or eligible employee in a health benefit plan offered by a health plan is eligible to be covered for benefits as determined by the individual's employer.

Sec. 2. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding section 36-2912.04, to read:

36-2912.04. Medical loss subsidies; required information

THE ADMINISTRATION SHALL ESTABLISH UTILIZATION MANAGEMENT CONTROL STANDARDS FOR PARTICIPATING PLANS THAT MEET NATIONALLY RECOGNIZED STANDARDS FOR MANAGED CARE UTILIZATION. PLANS THAT DO NOT MEET THESE STANDARDS ARE NOT ELIGIBLE FOR STOP-LOSS COVERAGE FOR COSTS IN EXCESS OF THESE STANDARDS.

Sec. 3. Healthcare group; employee groups; continued eligibility

Notwithstanding section 36-2912, Arizona Revised Statutes, as amended by this act, an employee group of one eligible employee that was enrolled in healthcare group before the effective date of this act may continue to be enrolled in healthcare group if the employee group continues to meet all other applicable requirements for enrollment.

Sec. 4. Healthcare group; temporary enrollment limit

Notwithstanding section 36-2912, Arizona Revised Statutes, as amended by this act, beginning August 1, 2008 and ending on June 30, 2009, healthcare group shall limit employer group enrollment to not more than ten per cent more than the number of employer groups enrolled in the program as of July 31, 2008. Enrollment priority shall be given to uninsured groups."

Amend title to conform

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